RUPTURE OF THE UTERUS.*

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I BRING this subject before the profession not because I have been making any experiments in this line, neither for the reason that my experience has been extensive, nor because I have anything new or original to offer. I present the matter chiefly for the purpose of calling special attention to some errors in the practice of obstetrics, and to emphasize the necessity for certain procedures and the equal necessity for the avoidance of others.

The Chairman of the Committee on Scientific Programme has made diligent search among the members of the society in order to ascertain who was willing to open the discussion on this question, but neither he nor myself has been able to find any one who has met with a case. The accident is a rare one, yet I believe it is now and then met with and not recognized, so that the actual number of cases is most likely greater than statistics would seem to indicate. The accident is not a frequent one in lying-in hospitals. It is most likely to occur in the outlying districts where either no physician is secured, or, if secured, he is found to be too conservative to interfere in the progress of labor.

The many predisposing causes, such as overdistension of the uterus from hydramnios, hydrocephalous, fatty and calcareous degenerations, malignancy, cicatrices, we shall pass over without comment. The determining causes lie in the too greatly prolonged second stage of labor. The only exception is a malignancy of the cervix which prevents dilatation and puts the tissues in a condition to be easily torn. Aside from this, the accident, as I have said, results when the second stage of labor is too greatly prolonged. Whether this has for its cause a lack of proportion between the canal and the presenting part, whether there is a malpresentation, such as an occipito-posterior position, or whatever else may interfere with the advance of the presenting part, it is to be remembered that in the first as well as the second stage of labor only the upper two-thirds of the uterus contracts while the lower third dilates and distends. After the expulsive pains begin the upper two-thirds of the uterus becomes thicker and stronger, while the lower third becomes thinner and weaker. If the progress is not commensurate with the distention the result will finally be that this thinned portion of the uterine wall must give way.

My experience with this accident is limited to a single case, and although this occurred nearly fifteen years ago, all the circumstances were so indelibly impressed upon my mind that the case is yet very clear. It has never been reported and therefore I shall report it now. The patient, Mrs. M., was a woman of Irish birth, strong and healthy, and at the time I was called to see her was in her third labor. The first stage proceeded without any unusual occurrence; the second stage began when dilatation was complete, the membranes had ruptured and the liquor amnii had escaped. The patient gave a history of two difficult labors, but in each was delivered of a living child. The expulsive pains were frequent and powerful. I watched for two hours, during which time the head did not engage. I then determined to interfere and attempted to apply the forceps. The head, however, was so high and apparently so large that I could not succeed in getting the instruments locked. After repeated efforts and failures I desisted and sent for help. An hour passed before the consultant arrived, during which time I had lessened the pains by morphia and chloroform.

The consultant was an aged man of large experience. After hearing the history of the case he advised another attempt at the forceps, which was made by himself, but with the same results that I had already secured. He was not able to lock the instruments. By this time the patient had recovered from the sedatives and the pains had returned with renewed vigor. Within a few minutes, however, I noticed that the pulse increased from 70 and 80 per minute to about 140, and the uterine contractions ceased. My consultant laid down his instruments, rolled up his sleeves, put his hand into the uterus and performed version. He succeeded in a short time in delivering the body of the child. I was administering the anaesthetic. He was unable, however, to deliver the head. He made repeated attempts with the final result that he severed the body from the head, which latter remained in utero. He then asked me to deliver the head. I replied that I considered that impossible under our present plan of procedure, and that there was nothing to do but to crush the head with the cephalotribe or to do abdominal section. He made another effort to deliver, but in a few minutes desisted, and informed me that he was worn out, would return to town and send another physician. I implored him not to do this, but remain with me and let us send for more help because the condition of the patient was getting more and more serious. He, however, persisted and drove away. From that time until another physician arrived, which was fully an hour and a half, I stimulated the patient, but made no further effort to deliver. There were no uterine contractions, and no external evidences of hemorrhage.

When the second consultant came he made an examination and as he turned to me with a look of horror upon his face and asked me to make an examination also, I was satisfied that something very serious had been discovered.

* Read at the Thirty-third Annual Meeting of the State Society, Santa Barbara, April 21-23, 1903.

Upon introducing the hand into the uterus it passed through a rent in the uterine wall and the undelivered head was discovered to have escaped from the uterine cavity and was lying under the stomach. While we were making hasty preparations to open the abdomen the patient went into profound collapse, and in a few minutes was dead.

An autopsy revealed a rupture in the uterus, at right angles to the cervix anteriorly just above the vaginal junction, about two inches in length, and another tear extending at right angles to this along the anterior uterine wall to the extent of six inches, and reaching almost to the fundus. There was considerable hemorrhage, but not sufficient to have caused death. The patient died from shock. It was easy to understand that the long second stage, during which the force of the uterine contractions had been expended in dilating and thinning the uterus, the result was that when turning was attempted this thin portion gave way. It was also very apparent what measures should have been adopted earlier. The head proved to be at least an inch greater in diameter than was any portion of the superior strait, and could not have been delivered except by performing craniotomy. This would have been extremely difficult, since the head was not engaged, and the course which would have offered the patient the best chance for life was abdominal section either during the first stage or early in the second.

I wish again to emphasize the fact that the real cause for rupture of the uterus lies in a prolonged second stage, and to call special attention to the two prominent symptoms of rupture, namely, rapid increase of the pulse rate and the entire cessation of uterine contractions.

DISCUSSION.

Dr. G. A. Cole, Los Angeles—I was very much interested in the report of this case. It reminded me of the report of a case I heard read in 1899 before the British Medical Association on this same subject, by a gentleman who was called in to see a woman who had presented a history of labor some twenty-four hours before. She had had very severe pains and the country practitioner had left her. Twenty-four hours later the author of the paper had been called and found the child in the abdominal cavity, ruptured uterus having occurred. There were two or three very interesting points; first, that the pains had ceased entirely on the rupture of the uterus. The patient had been in such a condition that the attending physician had gone off and left her and had not noticed the rupture of the uterus. And furthermore the patient, after the rupture, had been in such a condition that she was able to walk over a mile. The patient died; the abdomen was opened, but owing to shock and sepsis, the patient eventually died.

Dr. O. O. Witherbee, Los Angeles—I had a case of ruptured uterus exactly like the report, in which instance the second stage was prolonged, pains unusually vigorous and rather free hemorrhage previous to birth of child, but as child passed through there was little or no hemorrhage. On making careful examination, I found a rent of unusual length in the left aspect of the vaginal wall, including the cervix and lower portion of the uterine body. Our attention was directed to it by the free hemorrhage. Fortunately I recognized it in time to prevent hemorrhage of such severity as to cause death, and with the aid of two nurses assisting me, and with pressure from without, I held the hemorrhage in control and fortunately was able to stitch this rent up with catgut. I speak of it merely as it comes to my mind. It certainly did approach abdominal rupture with hemorrhage so free that it endangered the life of the patient.

PERSONALS.

Dr. J. L. Maupin of Fresno, who has been taking a post-graduate course in New York and Philadelphia, returned home on December 15th, and has resumed practice.

Dr. Mrs. Jessie D. Hare, who retired from the practice of medicine a few years ago, has again entered the ranks and become a member of the Fresno County Medical Society.

Dr. J. H. Parsegan, an active member of the Fresno County Medical Society, has located in San Francisco.

Dr. J. R. Liverman, who has been located at Kingsburg for the past year, has removed and is temporarily in San Francisco, taking a post-graduate course.

Dr. C. J. Kjaerbye, a former practitioner of Salt Lake City, Utah, has opened offices in Fresno.

Dr. F. C. Galehouse of San Francisco has located in Fresno, with the intention of making that place his home.

Drs. George McChesney, William G. Moore and Robert A. McLean of San Francisco are in New York. The two former are taking a special course in surgery.

Professor M. Allen Starr, M. D., LL. D., of the Medical Department of Columbia University, of New York, has been elected a corresponding member of the Neurological Society of the United Kingdom, London. Dr. Weir Mitchell is the only other American member.

Dr. James P. Booth has removed from Needles, San Bernardino County, to Los Angeles, and has opened offices in the Bryson Block.

Secret Remedies—"Why cannot the doctors write their own prescriptions and adapt their remedies to the ever-varying exigencies of disease? Why should the vender of proprietary and secret remedies be upheld by so many of the profession, when Edward Jenner, after twenty-two years of laborious experimentation and research, freely gave the priceless boon attained to mankind, and when he could have made countless billions of money from the whole world by dispensing it as a secret and sovereign remedy against a loathsome and desolating scourge?"—William T. Howard, M. D., in An. Add. to Maryland Med. Society.

An obelisk of unpolished gray granite has been placed over Virchow's grave in the old Matthai graveyard, Berlin. It bears on one side a black marble tablet, on which is inscribed "Rudolph Virchow," and the date of his birth and death. A statue of Virchow will also be erected near the place where his scientific work was conducted.

A statue in honor of the eminent French neurologist, M. Charcot, has been erected at Lemolon-les-Bains.